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	16G016	A. BUILDING _____ B. WING _____	C 04/21/2021

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W 000	INITIAL COMMENTS The investigations of #95674-C, #95069-C and #96723-I resulted in deficient practices cited at W189. The investigation of #96837-I resulted in deficiencies cited at W155, W159 and W191. The investigation of #96879-I resulted in deficiencies cited at W153 and W191. The annual health facility survey resulted in deficiencies cited at W104, W124, W159, W189, W191, W249, W259, W260, W268, W323, W334, W352, W382 and W441. A focused infection control survey was also completed and resulted in no concerns identified.	W 000	POC 8/9/21	
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review the Governing Body failed to provide adequate direction and oversight to ensure the safety of clients. The facility failed to take action in a timely manner to ensure the Wanderguard alarm system functioned correctly. Additionally, the facility failed to ensure staff training to use alternate methods to prevent clients from leaving the facility unsupervised. This potentially affected 2 of 2 clients who used the Wanderguard system	W 104	W 104 Governing Body Mosaic will ensure that all individuals that they serve are safe and all adaptive equipment including alarms are in working order. There will be checks daily of alarms to ensure they are working properly. If a checks shows that the alarms is not working, DSA or DSS will contact the maintenance department and they will test the alarms to troubleshoot why it is not working. If they can not find the cause they will put an alternative alarm on the doors. When that alternate alarm is engaged, the maintenance dept will train the DSS or DSA on how the alternative alarm works and each shift as they come to work will be trained on the alternative alarm until all employees have	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 104	Continued From page 1 due to a history of elopement attempts (Client #1 and Client #4). Finding follows: Observation on 4/05/21 at 4:29 p.m. revealed Client #1 walked out the front door and the Wanderguard system failed to activate the alarm. At 4:31 p.m. surveyor asked the Direct Support Supervisor (DSA) A to have Client #4 walk out the front door. Client #4 walked out the front door and the Wanderguard system failed to activate the alarm until after the client walked back in the door. Both Client #1 and Client #4 wore Wanderguard monitors/bracelets due to a history of elopement attempts. The monitors should have triggered the Wanderguard alarm to sound when they went out the exit door. Observation on 4/06/21 at 6:50 a.m. Client #4 answered the front door. The Wanderguard system failed to activate the alarm until the client walked back in the door. Observation on 4/06/21 at 7:33 a.m. revealed DSA B held the Wanderguard remote next to the Wanderguard unit by the front exit door and side exit doors. She also held the Wanderguard remote next to the bracelets for Client #1 and Client #4 until it lit green on the screen. The remote indicated with a green screen each door unit and each bracelet worked. DSA B indicated the facility CMA checked the Wanderguard system every morning by using the remote. Observation on 4/13/21 at 11:27 a.m. revealed Client #4 answered the front door. The Wanderguard system failed to activate the alarm until the client walked back in the door. Observation on 4/13/21 at 11:38 a.m. revealed	W 104	Continue W104 been trained. Staff will put a T-log out, so all employees are aware that there is an alternative alarm on the doors. All employees will be retrained on responding to the door alarm going off. Each time the door alarm goes off, the closest employee will step out to the doors to see who is entering or leaving the home. The DSS will check the monitors on a regular basis to ensure they have not expired which will make them malfunction. DSS will also check/change the batteries on a monthly basis to ensure they are is good working order. Person(s) Responsible: Direct Support Supervisor (DSS) Maintenance Dept.	07-31-2021

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DSA B held the Wanderguard remote next to the Wanderguard unit by the front exit door and side exit doors. She held the Wanderguard remote next to each bracelet for Client #1 and Client #4 until it lit green on the screen. The remote indicated with a green screen each door unit and each bracelet worked.

Observation on 4/05/21 and 4/13/21 also revealed small plastic alarms had been attached to the exit doors, which had an "on" and "off" switch. Those alarms sounded each time the exit door opened. The sound made by the small alarms was a different sound from the Wanderguard alarm.

Observation on 4/05/21 at 3:59 p.m. revealed the CMA entered the front door and the alarm sounded. Direct Support Associate (DSA) H continued meal preparation in the kitchen and DSA G continued interview with the surveyor. Staff failed to respond when the alarm sounded.

Observation on 4/05/21 at 4:46 p.m. DSS B exited the front door and the alarm sounded. Staff failed to check to see who exited the front door.

When interviewed on 4/05/21 at 4:29 p.m. Direct Support Associate (DSA) G said the Wanderguard alarm had worked previously to her knowledge. She was not aware it had not been functioning correctly.

Record review on 4/13/21 revealed Client #4 had eloped from the facility on 3/20/21. The Wanderguard system failed to alarm when Client #4 exited the building.

When interviewed on 4/05/21 at 4:31 p.m. DSS A

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W 104	Continued From page 3	W 104		

acknowledged the facility was aware the Wanderguard system was not working correctly and she thought the facility had ordered a new Wanderguard system. DSS A said the facility put the additional small alarms on the exit doors because the Wanderguard system had been malfunctioning.

When interviewed on 4/06/21 at 6:54 a.m. DSA B commented the Wanderguard system had not worked correctly since Client #4 had eloped on 3/20/21. DSA B said it only worked when Client #4 entered the facility instead of when he exited the facility.

When interviewed on 4/13/21 at 11:49 a.m. DSA B stated the facility installed the additional exit door alarms after Client #4 eloped from the facility on 3/20/21. DSA B acknowledged she received verbal notification to keep the alarms turned on, but had not received training regarding using the new door alarms as a replacement for the malfunctioning Wanderguard system.

When interviewed on 4/13/21 at 11:55 a.m. DSA K stated the facility trained her on the Wanderguard system. When asked about the additional exit door alarms, she stated she thought the alarms were there for extra assistance in the springtime. DSA K said she witnessed several times the additional alarm on the front exit door was turned off when she entered the facility.

When interviewed on 4/13/21 at 10:50 a.m. the Associate Director (AD) acknowledged Client #4 left the facility without staff knowledge on 3/20/21. The Wanderguard alarm didn't sound when Client #4 left the facility. The facility notified DIA of the

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W 104	Continued From page 4 elopement and indicated they were working on the problem with the Wanderguard. The AD stated the Maintenance Specialist was in charge of the Wanderguard system and he had contacted the company. She did not indicate the facility had ordered a new Wanderguard system. The AD acknowledged the facility provided no formal training for the additional exit door alarms. She said the facility had informed the staff the additional alarms were there in case the Wanderguard system did not work. When interviewed on 4/13/21 at 11:15 a.m. the Maintenance Specialist acknowledged he called the Wanderguard company and made what adjustments he could to the unit. He stated the malfunction was either the monitors/bracelets or the Wanderguard unit connected to the front door. He knew there had been problems in recent weeks with the alarm not sounding when a client exited the building, but it worked when the client came back inside. The Maintenance Specialist said the staff at the facility was going to change the bracelets but he had not checked back to see if that solved the problem. He said no one informed him the Wanderguard system malfunctioned on 4/05/21. The Maintenance Specialist indicated the facility might need to purchase a new Wanderguard system if the bracelets were changed and the system was still malfunctioning. He indicated he didn't know if the system was currently working correctly. The staff at the facility was supposed to check the system daily and then notify him of problems.	W 104		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients.	W 124	W 124 Protection of Client Rights Mosaic will ensure that the rights of all individuals are in their best interest, by informing all parties involved of informed	

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W 124	Continued From page 5 Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure written informed consent. This affected 3 of 3 sample clients (Client #1, Client #2 and Client #3). Finding follows: 1. Record review on 4/07/21 revealed the Informed Consent documented for Client #1 on 3/08/21 included behavior modifying medication, environmental restrictions and other restrictive measures. The consent lacked information regarding possible medication side effects, risks and benefits of treatment and possible alternative treatments. When interviewed on 4/14/21 at 11:19 a.m. the Qualified Intellectual Disability Professional (QIDP) confirmed the consent failed to include the risk and benefits of treatment, possible side effects of behavior modifying medications and possible alternative treatments. 2. Record review on 04/08/21 revealed a written informed consent for Client #2, with no effective dates. The consent included behavior modifying medication, environmental restrictions and other restrictive measures. The consent lacked information regarding possible medication side effects, risks and benefits of treatment and possible alternative treatments. The written informed consent had been signed by facility staff	W 124	Continue W124 consents with all information included: medication increase/decrease, medication side affects, risks and benefits of treatment and restrictive measures. The QIDP will ensure all necessary information will be in the informed consent and all informed consents will be taken to HRC for approval. Case file reviews are completed on a monthly basis and informed consent will be on the review to check to ensure all of the information is correct and on the informed consent. Case reviews are complete monthly on the individuals that had their Annual ISP the month prior. Person(s) Responsible: QIDP	07.31.2021

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W 124	Continued From page 6 in October 2020, but lacked a signature from the legal guardian. Client #2's Individual Support Plan (ISP) meeting was held on 12/10/20. Client #2's guardian had been invited to the ISP but did not attend the meeting, where the team reviewed the informed consent and restrictive measures. Record review indicated Client #2 had a diagnosis including Severe Intellectual Disability, Autistic Disorder, Impulse Control, and PICA (ingestion of non-edibles). When interviewed on 4/12/21 at 3:08 p.m. the Associate Director (AD) said Client #2's guardian was no longer able to make decisions for himself and Client #2. The AD stated a family friend filed for guardianship for Client #2 in January 2021. When interviewed on 4/14/21 at 11:19 a.m. the QIDP confirmed the consent failed to include the risk and benefits of treatment, possible side effects of modifying medications and the possible alternatives. 3. Record review on 4/08/21 revealed the Informed Consent documented for Client #3 on 4/06/21 included behavior modifying medication, environmental restrictions and other restrictive measures. The consent lacked information regarding possible medication side effects, risks and benefits of treatment and possible alternative treatments. When interviewed on 4/14/21 at 11:19 a.m. the QIDP confirmed the consent failed to include the risk and benefits of treatment, possible side effects of behavior modifying medications and possible alternative treatments.	W 124		
W 153	STAFF TREATMENT OF CLIENTS	W 153		

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W 153	Continued From page 7 CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of abuse/mistreatment to the appropriate state agency (Department of Inspections and Appeals). This affected 1 client identified during the investigation of #96879-I (Client #1). Finding follows: Record review regarding a separate incident revealed when the facility conducted an investigation involving Direct Support Associate (DSA) E, they learned of additional staff concerns regarding DSA E. During her facility interview on 2/05/21, DSA F spoke of an incident that occurred on 12/21/20. She reported Client #1 returned from a visit with his father around 6:30 p.m. on 12/21/20. DSA E guided Client #1 to his room and told him to go to bed. DSA E did not allow Client #1 to leave his room for a period of time and kept telling him to go to bed. Client #1 came out of his room later in the evening for a snack. DSA F said she reported the incident the same evening to the supervisor. Additional record review revealed no General Event Report regarding this incident could be located in Client #1's chart. When interviewed on 4/07/21 at 4:05 p.m. the	W 153	W153 Staff Treatment of Clients Mosaic will ensure the safety of all of our individuals, from abuse, and/or mistreatment by ensuring that staff are retrained on reporting abuse and/or mistreatment. All Mosaic employees complete the state approved Dependent Adult Abuse Reporting Training within 6 months of their date of hire. Annually all Mosaic employees take the Abuse Reporting refresher course. All employees will be retrained on Mosaic's policy on reporting all abuse, neglect and mistreatment. When an allegation has been reported, the alleged perpetrator will be separated immediately from the victim. The administrator will contact the Investigation Coordinator to get an internal investigation initiated. The administer will ensure there is a completed GER (general event record) and will report to DIA immediately. The perpetrator will remain separated until DIA's investigation has been completed unless Mosaic's investigation was founded and the perpetrator is released from Mosaic. Person(s) Responsible: Associate Director Program Manager Direct Support Supervisor	06/29/2021

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Associate Director(AD) said no supervisor informed management staff of the allegation made by DSA F regarding the incident on 12/21/20. She stated the supervisor should have reported it to management staff. The facility management staff first heard of the allegation on 2/05/21 when conducting an investigation regarding another incident involving DSA E. The AD acknowledged the facility did not investigate the allegation regarding the incident on 12/21/20 or report it to the Department of Inspections and Appeals (DIA). The AD stated, "That's a problem."

During a follow-up interview on 4/08/21 at 8:45 a.m. the AD reported she reviewed the incident with the agency Executive Director and they determined the facility didn't need to conduct a formal investigation or report the incident to DIA because it was not an allegation of abuse. The AD said it was her understanding that DSA E told Client #1 to stay in his room, but did not physically block his egress from the room. He came out of his room later in the evening for a snack. The AD said management staff questioned Direct Support Supervisor (DSS) A about the incident when they learned of it in February 2021. DSS A said she checked into the allegation at the time and found no evidence of abuse. The AD provided a hand written summary written by DSS A dated 12/30/20 regarding the incident. DSS A wrote DSA F made the allegation on 12/27/20 that DSA E had blocked Client #1 from leaving his room. DSS A noted she talked with DSA E on 12/29/20 and she denied the allegation. DSS A indicated she spoke with DSA E regarding clients having the right to have freedom of movement in their home. DSS A provided the summary to the AD on or around 4/08/21.

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When interviewed on 4/08/21 at 10:45 a.m. DSS A stated she recalled DSA F told her of the 12/21/20 incident on 12/27/20. DSA F told DSS A that DSA E stood in front of Client #1's door to block him from leaving his room. DSS A said she asked DSA E about the incident and she denied it. DSS A said she felt like she addressed the situation. She said she told the Program Manager about the incident around the time it occurred. DSS A said she wrote a summary of the incident on 12/30/20, but hadn't shared the written summary with management staff until she gave it to the AD-ICF on 4/08/21.

When interviewed on on 4/09/21 at 11:00 a.m. the Program Manager said she was new to her role at the time of the incident in late December 2020. She said she didn't recall DSS A telling her about the incident regarding DSA E keeping Client #1 in his room. The AD was also present for the interview and said they didn't believe DSA E could have physically blocked Client #1 in his room if he didn't want to stay there. DSS A talked with both staff about the incident around the time it happened. The facility didn't report it to DIA. The surveyor encouraged the facility to report the allegation of abuse to DIA as soon as possible.

When interviewed on 4/12/21 at 2:10 p.m. DSA F stated she recalled the incident on 12/21/20 between DSA E and Client #1. DSA F said Client #1 had returned from a family outing around 6:30 p.m. DSA E guided Client #1 to his room, which was typical when he returned from outings to see if he needed to be changed. DSA F then heard DSA E yelling at Client #1 to go to bed. Client #1 typically did not go to bed so early in the evening. DSA E stood in Client #1's doorway and blocked

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W 153	Continued From page 10 the client from leaving his bedroom. DSA F saw Client #1 try to leave the room, but DSA E blocked him with her body and arms. DSA E told Client #1 to go to bed and pointed at his bed. DSA F said DSA E blocked Client #1's doorway and prevented him from leaving for several minutes. DSA E later checked on Client #1 and saw him lying on his bed. He later left his room to come out for an evening snack. DSA F said she called a supervisor to report the incident. The agency Abuse, Neglect and Exploitation policy noted all people supported should be treated with dignity and respect. According to the policy immediate action should be taken to ensure the client is protected from further harm. The incident should be immediately reported and the agency should follow the notification expectations for state regulatory agencies. Any suspected incident of abuse, neglect or exploitation must be documented utilizing a General Event Report. A facility investigation should be initiated immediately upon receipt of an allegation.	W 153		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to separate an alleged perpetrator from the client he reportedly mistreated. This affected 1 client identified during the investigation of #96837-I (Client #1). Finding follows:	W 155	W155 Staff Treatment of Clients Mosaic will ensure the safety of all of our individuals, from abuse, and/or mistreatment by ensuring that staff are retrained on reporting abuse and/or mistreatment. All Mosaic employees complete the state approved Dependent Adult Abuse Reporting Training within 6 months of their date of hire. Annually all Mosaic employees take the Abuse Reporting refresher course. All employees will be retrained on Mosaic's policy on reporting all abuse, neglect and mistreatment. When an allegation has been reported, the alleged perpetrator will	

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W 155	Continued From page 11 Observation on 4/06/21 at approximately 7:00 a.m. revealed Client #4 told Direct Support Associate (DSA) A DSA H grabbed Client #1 and dragged him down the hallway the night before. Client #4 demonstrated a grabbing motion above his wrist. Approximately 7:30 a.m. Client #4 again indicated DSA H had grabbed Client #1's arm and dragged him to his room. DSA A promptly reported the allegation to a management staff by phone. Observation on 4/06/21 at 3:16 p.m. revealed DSA H working at the facility with Client #1. DSA H remained at the facility until the surveyor left at approximately 4:25 p.m. During interview on 4/06/21 at 3:20 p.m. the Associate Director (AD) said the facility looked into an allegation of abuse that reportedly occurred at the facility on the evening of 4/05/21. She indicated the alleged incident on the evening of 4/05/21 happened during the time period when Client #1 returned from a visit with his father. The AD stated Client #1 typically had difficulty with returning to the facility after an outing with his father. When asked why DSA H had not been separated from working with Client #1, the AD said a facility investigator had talked with Client #1's father and determined abuse had not occurred. On 4/06/21 at 4:10 p.m., the AD provided a summary of a conversation with Client #1's father dated 4/06/21 and written by the Program Manager. According to the written summary, Client #1's father brought him back to the facility around 7:00 p.m. on 4/05/21. Client #1 did not want to exit his father's vehicle, so his father and	W 155	Continued W155 be separated immediately from the victim. The administrator will contact the Investigation Coordinator to get an internal investigation initiated. The administer will ensure there is a completed GER (general event record) and will report to DIA immediately. The perpetrator will remain separated until DIA's investigation has been completed unless Mosaic's investigation was founded and the perpetrator is released from Mosaic. Person(s) Responsible: Associate Director Program Manager Direct Support Supervisor	06.29.2021

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W 155	Continued From page 12 step-mother physically assisted him from the vehicle to an agency wheelchair. Client #1's father said they got Client #1 inside the facility door and he then left. Client #1's father indicated he was not present in the facility after Client #1 went inside. During interview on 4/06/21 at approximately 4:35 p.m. the surveyors explained to the AD the allegation made by Client #4 was regarding what occurred after Client #1 went into the facility from his family outing, not what transpired outside the facility. The AD acknowledged the facility had not thoroughly investigated the allegation that DSA H grabbed Client #1 and dragged him down the hallway. She said she thought Client #1's father had been present for the entire interaction. The AD called the facility and asked them to immediately separate DSA H from Client #1 at approximately 4:45 p.m. The agency Abuse, Neglect and Exploitation policy noted all people supported should be treated with dignity and respect. According to the policy immediate action should be taken to ensure the client is protected from further harm.	W 155		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the Qualified Intellectual Disability Professional (QIDP) failed to develop and monitor programs to meet client needs. This affected 3 of 3 sample clients (Client #1, Client #2 and Client	W 159	W 159 QIDP Mosaic will ensure that all programs will be monitored to meet the individuals needs. The QIDP will complete Q notes on a monthly basis to monitor each individuals progress and needs. When the QIDP completes the Q Notes, there is a T-log put out by QIDP, then the DSS will go in and make notes of their review and make recommendations. QIDP will go back in and make needed changes if any. QIDP will ensure that all consultants recommendations	

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W 159	Continued From page 13 #1), 1 client identified during the investigation of #95674-C (Client #5) and 1 client identified during the investigation of #96837-I (Client #1). Finding follows: 1. Record review on 4/08/21 revealed Client #3's Physical Therapy (PT) evaluation dated 10/29/19 noted the following recommendations: "continue regular PROM (passive range of motion) and lower extremity exercises with emphasis on hip abduction... knee extension and using abduction pillow when she is sitting in wheelchair (need to order one)... black wedge under wheelchair seat 2 hours daily, and hip extension in prone... lie prone on a wedge or mat for 15-30 minutes on a daily basis to encourage hip extension... PROM on both upper extremities, prone or on all 4's with bolster under stomach." Client #3's Individual Support Plan (ISP) held on 12/19/19 failed to include a program, procedure, or team discussion of the PT evaluation. No information regarding implementation of the PT exercises could be located in Client #3's record. When interviewed on 4/14/21 at 3:18 p.m. the Qualified Intellectual Disability Professional (QIDP) reported Client #3 had no program, procedure or staff documentation regarding the PROM and other PT exercises. 2. Observations on the afternoon of 4/05/21 and the morning of 4/06/21 revealed Client #1 did not use an electronic speech/communication device. Record review on 4/07/21 revealed Client #1's Speech and Language Evaluation dated 1/22/20 noted Client #1's Speech Generating Device (SGD) "is obtained for him to use in his home	W 159	are in the individuals plans as updates are completed. QIDP will ensure that all Adaptive Equipment is available and in working order. DSS, PM and QIDP will be completing monthly Teaching Plan Observations to ensure that the Teaching Plans are ran as written and adaptive equipment is used as written. DSS or designee will conduct Documentation audits on a weekly basis to ensure that all needed documentation is present for the needed data for the programs. Retaining with DSS on documentation auditing by the Program Manager. Person(s) Responsible: QIDP Direct Support Supervisor Program Manager	07.31.2021

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environment, further assessment will be conducted to determine the number of buttons per page he should have to access to communicate his wants and needs. Specific SGD goals can be established once further evaluation of his skill level can be conducted."

When interviewed on 4/07/21 at 4:17 p.m. QIDP acknowledged Client #1 graduated in May of 2020, however the Speech and Language Pathologist (SLP) picked up the SGD on 4/05/21 to program the device. QIDP stated the previous QIDP failed to get the device to the SLP for programming.

3. Record review on 4/07/21 revealed the following:
a. Client #1's QIDP review for December 2020 evaluated the client's eight program goals. The QIDP noted the range of data trials to be ¼ to ½ of missed documentation for the month of December. The QIDP noted the data would not count towards the client's goals and will continue to monitor.

b. The QIDP review for January 2021 evaluated Client #1's eight program goals. The QIDP noted the range of data trials to be ½ to ¾ of missed documentation for the month of January. The QIDP noted the data would not count towards the client's goals and will continue to run as written.

c. The QIDP review for February 2021 evaluated Client #1's eight program goals. The QIDP noted the range of the data trails to be ½ to ¾ of missed documentation and his communication program with no data collected. The QIDP noted the data would not count towards client's goals and will

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continue to run as written. The communication program had additional questions if the program was ran or staff not documenting. QIDP noted on 3/24/21 "will begin working with the Direct Support Supervisor (DSS) to establish routine audits of documentation to ensure better data collection."

When interviewed on 4/07/21 at 4:36 p.m. QIDP reviewed the dates of the documentation training for supervisors, which she trained on 2/24/21 and 3/24/21. QIDP stated she verbally trained the supervisors on the tracking for the data.

4. Record review on 4/08/21 revealed the following:
a. Client #2's QIDP review for December 2020 evaluated five programs. The QIDP noted missing approximately ½ the data for each program. The QIDP noted the data would not count towards the goal, however at times the QIDP revised programs for Client #2.

b. The QIDP review for January 2021 noted a range of 1/3 to 2/3 data trials missing and no data for the Leisure Activity goal. The QIDP noted the data would not count toward the goal and to continue as written.

c. The QIDP review for February 2021 noted a range of 1/3 to 2/3 data trials missing and there was no data for the Leisure Activity goal. The QIDP questioned in the report was the Leisure Activity goal worked on. In addition, the data would not count towards the goal and continue as written

When interviewed on 4/07/21 at 4:36 p.m. QIDP

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reviewed the dates of the documentation training for supervisors, which she trained on 2/24/21 and 3/24/21. QIDP states she verbally trained the supervisors on the tracking for the data.

5. Record review on 4/08/21 revealed the following:
a. Client #3's QIDP review for December 2020 evaluated the client's four program goals. The QIDP noted ½ the documentation missing for the month and the data would not count toward the goal.

b. The QIDP review for January 2021 noted the range from ¼ to ½ the data missing and the dental goal had no data trials for the month.

c. The QIDP review for February 2021 noted ¾ of the data missed and the dental goal had not data trials for the month.

When interviewed on 4/07/21 at 4:36 p.m. QIDP reviewed the dates of the documentation training for supervisors, which she trained on 2/24/21 and 3/24/21. QIDP states she verbally trained the supervisors on the tracking for the data.

6. Record review on 4/05/21 revealed a General Event Report (GER) for Client #5 dated 12/28/20 written by Direct Support Associate (DSA) A. According the GER, DSA A noticed a "multicolored bruise on his right shoulder and right armpit" as she assisted Client #5 to prepare for his bath on the evening of 12/28/20. DSA A further described the bruise as "yellowish purple on his right shoulder and back near his armpit". The bruise was listed as an unknown injury.

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According to a nursing note on 12/29/20, the nurse examined Client #5's right posterior shoulder and axilla. The nurse documented, "It is a rather large area of bruising, 4+ inches. Staff are unaware of cause but (Client #5) is unstable due to right sided paralysis. No known falls but he could have bumped into a doorway or wall." Another nursing entry on the afternoon of 12/30/20 noted, "There are 3 areas of bruising - approximately 10 cm x 10 cm yellow/purple bruise to posterior right shoulder, 4 cm x 4 cm yellow/purple bruise to anterior right shoulder and 5 cm x 4 cm yellow/purple bruise to right bicep." The nursing note indicated Client #5 had an appointment to be seen at a local medical clinic on 1/05/21.

Additional record review revealed Client #5 was 56 years old at the time of the injury, with a diagnosis including Severe Intellectual Disability, Seizure Disorder, Cerebral Palsy, Flaccid Hemiplegia affecting Right Side and Drug Induced Tremor. Client #5 had very limited communication skills. He was independently ambulatory. Client #5 wore ankle/foot orthotics (AFO) both feet when ambulating.

The medical notes from Client #5's clinic appointment with the Advanced Registered Nurse Practitioner (ARNP) on 1/05/21 indicated Client #5 had a posterior right shoulder bruising in various stages of healing. He also had light yellow bruising to his right forearm medial and lateral superior to right elbow. An x-ray of his right shoulder revealed no fracture or dislocation. The ARNP recommended gait belt with transfers on 1/05/21.

Additional record review revealed Client #5's

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Individual Support Plan (ISP) in place at the time of the incident. The ISP had an effective date of 1/29/20. According to the ISP, Client #5 ambulated independently on level surfaces. The ISP noted Client #5 needed assistance to get in and out of the bathtub. He should be provided a 2-person support, along with the use of his foot box, when entering and exiting the bathtub to avoid slips or falls. An updated annual ISP was held on 2/25/21, with the exact same information provided in the previous ISP regarding Client #5's assistance for bathing. There was no mention of the use of a gait belt. A review of Client #5's "window sheet" used daily by staff, which contained information regarding his programs, diet, supervision level and other general information, did not include any information regarding assisting him in and out of the tub or the use of a gait belt. Client #5's Personal Schedule indicated he took a shower in the evening, but provided no information regarding assistance with bathing and no mention of a gait belt.

When interviewed on 4/13/21 at 9:20 a.m. the Associate Director (AD) confirmed Client #5's current ISP had the same information as the prior ISP regarding assistance during bathing, which was for two staff to assist Client #5 in and out of the tub. The AD confirmed Client #5's recent ISP had not been updated with information regarding the use of the gait belt.

When interviewed on 4/13/21 at 10:50 a.m. the Qualified Intellectual Disability Professional (QIDP) said she started working at the agency on 2/15/21. She said she was still in training on 2/25/21 and sat in on Client #5's ISP meeting. The QIDP stated she used the previous ISP as a

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guide and updated it based on discussion at the ISP meeting. She said she didn't know of the ARNP recommendation made 1/05/21 to use a gait belt, so she didn't include it in the most recent ISP.

7. Observation on 4/06/21 at approximately 7:00 a.m. revealed Client #4 told Direct Support Associate (DSA) A that DSA H grabbed Client #1 and dragged him the night before. Client #4 demonstrated a grabbing motion above his wrist. At approximately 7:30 a.m. Client #4 indicated DSA H had grabbed Client #1's arm and dragged him to his room. DSA A reported the incident to management staff.

When interviewed on 4/14/21 at 11:40 a.m. DSA A stated she promptly reported the allegation made by Client #4 on 4/06/21. She said she checked Client #1 for injuries after Client #4 made the allegation and saw none. DSA A said it could be challenging to get Client #1 to transition from one area to another, especially from his father's vehicle to the facility. She said Client #1 sometimes became behavioral and exhibited self-injurious behavior when his father brought him back to the facility after an outing. Staff tried snacks, electronic devices and the use of a wheelchair to try to convince Client #1 to go inside the facility. DSA A said Client #1 typically liked riding in a wheelchair, but it didn't always work. She said the staff needed more training on how to address the situation of Client #1 refusing to exit his father's vehicle and go into the facility.

When interviewed on 4/14/21 at 1:25 p.m. DSA G stated she was present when Client #1 arrived back at the facility with his parents on the evening

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of 4/05/21. Client #1 refused to get out of his father's vehicle, until his parents finally physically assisted him out of the vehicle. DSA G got a wheelchair and offered to push Client #1 around in it, but he was not interested. His parents physically picked him up and sat Client #1 in the wheelchair. DSA G and DSA H managed to get Client #1 through the first entry door into the vestibule, but then he got out of the wheelchair and tried to go back out the door. DSA G said DSA H put his arms around Client #1 and guided him inside the facility, through the second entry door. She said DSA H was behind Client #1 and put his arms around him like a bear hug, with DSA H's arms over Client #1's arms. DSA G said she felt that DSA H was just trying to get Client #1 safely inside, because sometimes he banged his head when upset. DSA G said she did not believe DSA H was being abusive or mistreating Client #1. She said it was common for Client #1 to refuse to leave his father's vehicle to go inside the facility when his father brought him back from outings. DSA G said staff had previously used Client #1's electronic tablet with videos to coax him into the facility, but his electronic tablet was broken and had not been replaced. She said staff had not received training on how to manage Client #1's refusal to go into the facility from his father's vehicle.

When interviewed on 4/14/21 at 1:40 p.m. the Certified Medication Assistant (CMA) stated she was present at the facility passing evening medications when Client #1's parents brought him back to the facility on 4/05/21. She said DSA G and DSA H were outside for 15-20 minutes trying to get Client #1 to come inside the facility. The CMA saw DSA H walk into the facility carrying Client #1 in a type of bear hug. Client #1

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had gone limp and refused to walk. DSA H held the client from behind, with his arms wrapped around him, but under Client #1's arms. The CMA said it was not uncommon for Client #1 to go limp and try to drop to the ground when he didn't want to do something. She said DSA H continued to carry Client #1 to his room, by holding him from behind. The CMA said DSA H did not appear to be angry with Client #1 or abusive, he was just trying to get the client to his room. The CMA stated it was always a problem when Client #1 came back from an outing with his parents because he didn't want to come inside.

When interviewed on 4/14/21 at 2:00 p.m. Client #1's father said Client #1 did not want to get out of the vehicle and go inside the facility on the evening of 4/05/21. He said this was not unusual. He and his wife physically got Client #1 out of their vehicle and put him in a wheelchair to take him into the facility. Client #1 got out of the wheelchair and tried to leave, but his father blocked him. Once they got him inside the first entry door, the parents left.

Record review on 4/14/21 of Client #1's Individual Support Program and Behavior Support Program revealed no information regarding how to manage refusals to transition from one area to another.

When interviewed on 4/14/21 at 1:50 p.m. the AD and the Program Manager confirmed the facility had not developed a program or procedure to address Client #1's ongoing difficulties with transitioning from vehicles to buildings. The AD noted it was also a problem with agency vehicles and going into other building, such as medical offices. She said Client #1's father had been picking him up for weekly visits for several

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W 159	Continued From page 22 months and the transition to return to the facility had been a continuing problem.	W 159		
W 190	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental needs. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure appropriate training for staff to effectively perform their job duties. This affected 1 of 3 sample clients (Client #2), 1 client identified during the investigation of #96879-I (Client #1), 1 client identified during the investigation of #95674-C (Client #5) and 1 client identified during the investigations of #95069-C and #96723-I (Client #3). Finding follows: 1. Observations on 4/05/21 at 3:38 p.m. revealed Direct Support Associate (DSA) G gave Client #3 a peanut butter jelly sandwich for a snack, which appeared to be bite size pieces with extra jelly added. DSA G left the table and went to the restroom. Client #3 ate four regular sized bites, three large bites, and made no attempt to drink her liquid while she ate without supervision. After Client #3 ate for two to three minutes without supervision, the surveyor asked DSA H to monitor her as she ate, due to concern for the client's safety. DSA G returned to the table after a few minutes and took over supervision of Client #3 but then left the area again at 3:44 p.m. for a minute while Client #3 ate unattended. Observations on 4/05/21 at 5:16 p.m. revealed	W 190	W 190 Staff training program Mosaic will ensure that all employees training is focused on skills and competencies directed toward client's developmental needs. All employees will be trained on any recommendations from dietitian, OT, PT, speech and all other consultants. The training will consist of a competency portion at the end of each training. QIDP will ensure all employees are trained on adaptive equipment needed for all programming. DSS, PM and QIDP will run random observation on programming and will debrief with all staff and the DSS on the findings of the observation. All programing will be put on the "Window sheets" as updates occur. New Specific training forms will be made for each individuals, which will have all of the likes, dislikes, routines, adaptive equipment, behaviors and diets that is needed by each individual. The specific trainings will be updated as changes may occur for each individual. Person(s) Responsible: QIDP Program Manager Direct Support Supervisor	08-09-2021

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DSA G left the table during dinner and Client #3 ate two large bites of food and a regular sized bite without staff supervision.

Observation on 4/06/21 at 7:45 a.m. revealed DSA J left the table at breakfast twice to go to the kitchen. Client #3 ate four of food bites while unattended.

Record review on 4/08/21 revealed Client #3's dietary evaluation dated 11/21/19 included a recommendation to "continue to supervise meal for coughing episodes." Client #3's Individual Support Plan (ISP) held on 12/19/19 failed to develop a program/procedure or have team discussion of the dietary evaluation for supervision at mealtime.

Interview on 4/20/21 at 10:30 a.m. the QIDP confirmed staff should have monitored Client #3 for appropriate bite sizes.

2. Observation on 4/05/21 at 5:19 p.m. to 5:25 p.m. revealed Client #2 did not have a micro switch next to her at supper to indicate she was finished.

Observation on 4/06/21 at 9:27 a.m. to 9:43 a.m. revealed Client #2 did not have a micro switch next to her at breakfast to indicate she was finished.

Record review on 4/08/21 revealed Client #2's most recent Speech and Language evaluation dated 12/29/19 with the recommendation that Client #2 "should continue to use a Big Mack switch with a pre-recorded message indicate that she is 'finished' eating." Client #2's Individual Support Plan (ISP) held on 12/10/20 failed to

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include a program, procedure, or team discussion regarding the use of a Big Mack switch to indicate Client #2 was finished eating.

When interviewed on 4/20/21 at 10:30 a.m. the QIDP stated Client #2 had an informal program to use a Big Mack switch to indicate she was "finished" eating. The QIDP had located the informal program in a computer program which was not the program used by the DSA staff.

3. Record review on 4/05/21 revealed a General Event Report (GER) for Client #5 dated 12/28/20 written by DSA A. According the GER, DSA A noticed a "multicolored bruise on his right shoulder and right armpit" as she assisted Client #5 to prepare for his bath on the evening of 12/28/20. DSA A further described the bruise as "yellowish purple on his right shoulder and back near his armpit". The bruise was listed as an unknown injury. According to a nursing note on 12/29/20, the nurse examined Client #5's right posterior shoulder and axilla. The nurse documented, "It is a rather large area of bruising, 4+ inches. Staff are unaware of cause but (Client #5) is unstable due to right sided paralysis. No known falls but he could have bumped into a doorway or wall." Another nursing entry on the afternoon of 12/30/20 noted, "There are 3 areas of bruising - approximately 10 cm x 10cm yellow/purple bruise to posterior right shoulder, 4 cm x 4cm yellow/purple bruise to anterior right shoulder and 5 cm x 4 cm yellow/purple bruise to right bicep." The nursing note indicated Client #5 had an appointment to be seen at a local medical clinic on 1/05/21.

Additional record review revealed Client #5 was 56 years old at the time of the injury, with a

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diagnosis including Severe Intellectual Disability, Seizure Disorder, Cerebral Palsy, Flaccid Hemiplegia affecting Right Side and Drug Induced Tremor. Client #5 had very limited communication skills. He was independently ambulatory. Client #5 wore ankle/foot orthotics (AFO) on both feet when ambulating.

The medical notes from Client #5's clinic appointment with the Advanced Registered Nurse Practitioner (ARNP) on 1/05/21 indicated Client #5 had a posterior right shoulder bruising in various stages of healing. He also had light yellow bruising to his right forearm medial and lateral superior to right elbow. An x-ray of his right shoulder revealed no fracture or dislocation. The ARNP recommended gait belt with transfers on 1/05/21.

When interviewed on 4/06/21 at 2:05 p.m. the ARNP stated she had concerns regarding Client #5's bruising to his right shoulder and arm area. She noted there was also bruising on the inside of his arm, which seemed inconsistent with a fall. One area of bruising looked like a possible hand print, but it was hard to say. The ARNP thought the bruised area seemed suspicious. The facility staff didn't know how the bruising occurred and Client #5 was unable to communicate what happened.

Record review on 4/06/21 revealed the facility investigation regarding Client #5's injury of unknown origin discovered on 12/28/20. The facility asked the staff who had worked with Client #5 around the time of the discovery of the bruised area if they knew of any falls or possible cause for the injury. All staff indicated they didn't know the cause of the injury, but one staff speculated it

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might have been related to getting in or out of the bathtub. Direct Support Supervisor (DSS) A concluded the injury might have occurred when staff assisted Client #5 in or out of the bathtub. She noted she would retrain staff on proper lift and assist.

Additional record review revealed Client #5's Individual Support Plan (ISP) in place at the time of the incident. The ISP had an effective date of 1/29/20. According to the ISP, Client #5 ambulated independently on level surfaces. The ISP noted Client #5 needed assistance to get in and out of the bathtub. He should be provided a 2-person support, along with the use of his foot box, when entering and exiting the bathtub to avoid slips or falls. An updated annual ISP was held on 2/25/21, with the exact same information provided in the previous ISP regarding Client #5's assistance for bathing. There was no mention of the use of a gait belt. A review of Client #5's "window sheet" used daily by staff, which contained information regarding his programs, diet, supervision level and other general information, did not include any information regarding assisting him in and out of the tub or the use of a gait belt. Client #5's Personal Schedule indicated he took a shower in the evening, but provided no information regarding assistance with bathing and no mention of a gait belt.

When interviewed on 4/06/21 at 3:10 p.m. DSS A stated she thought the injury might have been the result of a staff person holding onto Client #5's arm as he got into or out of the bathtub. She noted Client #5 bruised easily. DSS A said during the interview on 4/06/21 that staff should have been using a gait belt to assist Client #5 to get in

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and out of the tub around the time of 12/28/20. However, during a follow up interview on 4/13/21, DSS A stated staff had not been instructed to use a gait belt with Client #5 until the ARNP's recommendation on 1/05/21.

When interviewed on 4/07/21 at 1:45 p.m. DSA A stated around the time the bruise was discovered, staff provided minimal assistance to help Client #5 get in and out of the tub. One staff person provided assistance as he got in and out of the tub. Staff began using a gait belt after the bruise was discovered.

When interviewed on 4/06/21 at 3:55 p.m. DSA B said prior to the discovery of the bruise, staff provided minimal assistance as Client #5 got in and out of the tub. Client #5 used the bath rails and a foot box when as he entered and exited the tub. Since the bruise and visit to the ARNP, staff began using a gait belt to assist him in and out of the tub. DSA B said she was not aware Client #5's ISP indicated two staff should assist him in and out of the tub. She said just one staff person assisted him.

When interviewed on 4/07/21 at 11:50 a.m. former staff DSA C stated one staff person provided minimal assistance as Client #5 got in and out of the tub. Client #5 also used the hand rails to assist him. Staff began using a gait belt to assist Client #5 in early January, after he saw the ARNP for the bruise.

When interviewed on 4/07/21 at 10:00 p.m. DSA D said when she worked at the facility in December 2020, one staff person provided minimal assistance as Client #5 got in and out of the tub.

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When interviewed on 4/13/21 at 9:20 a.m. the Associate Director (AD) confirmed Client #5's ISP in place at the time the bruise was discovered on 12/28/20 indicated two staff should provide assistance while getting in and out of the tub. She acknowledged only one staff routinely assisted him in and out of the tub. The ARNP recommended the use of a gait belt at Client #5's medical appointment on 1/05/21. Although staff were apparently trained to use the gait belt, it was not added to Client #5's current ISP developed on 2/25/21. The current ISP had the same information as the prior ISP regarding assistance during bathing, which was for two staff to assist Client #5 in and out of the tub. The AD confirmed Client #5's recent ISP had not been updated with information regarding the use of the gait belt.

4. Observation on 4/05/21 at 2:00 p.m. revealed Client #3 laid in her bed on her right side. Staff got Client #3 out of bed and brought her to the common area of the home at approximately 3:20 p.m.

Record review on 4/05/21 revealed a Nursing Case Note dated 12/26/20 regarding a wound on Client #3's left mid buttock. Registered Nurse (RN) A noted she had first seen the reddened area, which was approximately 1 inch in diameter, on 12/25/20. She consulted with the Nurse Manager, who directed staff to keep Client #3 off her back as much as possible. RN A assessed the area again on 12/26/20 and saw that it had grown in size. She notified the Nurse Manager and they decided to send Client #3 to the local emergency room for evaluation. Records from the hospital emergency room on

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12/26/20 indicated a diagnosis of a left gluteal skin abscess. The hospital prescribed an antibiotic. A follow-up medical appointment on 1/04/21 noted the left lower back/upper gluteal abscess had improved.

Client #3 was 66 years old at the time of the abscess and had a diagnosis including Profound Intellectual Disability and Cerebral Palsy. According her to her ISP, held 12/19/19, which was in place at the time of the abscess, Client #3 used a manual wheelchair and relied on staff to move her where she needed to go. Client #3 could not bear her weight and used a mechanical lift for transfers. Staff should reposition Client #3 every two hours for at least 10 minutes. Per the ISP, the the repositioning was often done during personal cares. Client #3 could also be repositioned by laying down in her bed. The ISP did not indicate whether Client #3 needed to be repositioned or turned when in her bed.

According Client #3's Personal Schedule staff should lay her down between meals to alleviate pressure/pain. The schedule indicated staff should lay lay Client #3 down between approximately 9:00 a.m. and 11:00 a.m. and again between 1:00 p.m. and 3:00 p.m. The Personal Schedule noted Client #3 should not lie down for more than 1 1/2 hours.

Additional record review revealed the facility conducted an investigation regarding an allegation that DSA E left Client #3 in bed for most of the afternoon on 2/02/21. DSA F reported Client #3 was in bed when she entered the home at approximately 5:00 p.m. and again when she visited the home around 6:20 p.m. According to the facility investigation, DSA E

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admitted she left Client #3 in bed from the time she came into work at 2:00 p.m. until she got the client up around 6:30 p.m. DSA E said she had fed Client #3 dinner while in bed.

When interviewed on 4/12/21 at 2:25 p.m. DSA F stated she entered the facility around 5:00 p.m. on 2/02/21 to pass medications. She noticed she didn't see Client #3 in the common area. DSA F found Client #3 lying in her bed, awake. DSA F told Client #3's assigned staff, DSA E, to have Client #3 up in her wheelchair by the time of the 7:00 p.m. medication pass. When DSA F returned to the home around 6:20 p.m., she found Client #3 still in bed. Other staff in the facility told DSA F that Client #3 had been in bed the entire second shift (since 2:00 p.m.) and DSA E had fed Client #3 dinner in bed. DSA F reported the issue to management staff as possible neglect. DSA F said she had worked with DSA E on other days and noticed that DSA E left Client #3 in bed for long periods of time, getting her up only for dinner and evening medication pass. DSA F said she didn't think DSA E repositioned Client #3 when she was in bed for long periods. She questioned if this might have contributed to the abscess discovered on Client #3's buttocks on 12/28/20. DSA F said Client #3 could not roll over in bed by herself.

When interviewed on 4/08/21 at 10:35 a.m. DSA E recalled the afternoon of 2/02/21 when she left Client #3 in bed. DSA E said first shift staff typically laid Client #3 down in her bed after lunch. DSA E said she routinely got Client #3 up for dinner, which occurred around 5:00 p.m. DSA E said she fed Client #3 dinner in bed on 2/02/21 because she had been healing from a skin breakdown and DSA E was concerned that Client

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#3 would be up too long if she was in her wheelchair by 5:00 p.m. and stayed in the wheelchair through the 7:00 p.m. medication pass. During a follow-up interview on 4/12/21 at 3:20 p.m. DSA E said she had been trained to check on Client #3 every two hours to see if she needed her brief changed, but she had not been trained to reposition Client #3 every two hours when in bed.

When interviewed on 4/07/21 at 10:00 p.m. DSA D stated she worked with DSA E on the second shift of 2/02/21. DSA D said Client #3 was in bed when second shift staff arrived at the facility around 2:00 p.m. DSA E picked Client #3 as her assigned client, but left her in bed all afternoon. DSA E even fed Client #3 dinner in her bed. DSA E got Client #3 up after dinner when DSA F came to the house to pass evening medications. DSA D said she didn't know of clear guidelines regarding how long to leave Client #3 in bed during the day, but she thought it should not be over two hours. DSA D said she typically got Client #3 up between 3:00 p.m. and 4:00 p.m. from her afternoon nap.

When interviewed on 4/06/21 at 3:45 p.m. DSA B said she typically worked first shift at the facility. She said first shift staff usually transferred Client #3 to her bed after lunch, around 12:30 p.m. or 1:00 p.m. She said she wasn't aware of specific guidelines regarding how long Client #3 should lie down, but she said she thought it was typically 1 1/2 to 2 hours.

When interviewed on 4/07/21 at 1:55 p.m. DSA A stated there were times when she worked at the facility when she felt staff left Client #3 in bed too long, but she was unable to name specific staff or dates. DSA A said she was not aware of specific

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W 190	Continued From page 32 guidelines regarding how long Client #3 should be in bed. When interviewed on 4/12/21 at 3:00 p.m. the Associate Director and the Program Manager confirmed Client #3 was unable to roll over or reposition herself. They said staff should reposition her every two hours.	W 190		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Observation, interviews and record review revealed the facility failed to adequately train staff to manage ongoing behavioral challenges. This affected 2 of 2 clients who used the Wanderguard system (Client #1 and Client #4) and 1 client identified during the investigations of #96837-I (Client #1). Findings follow: 1. Observation on 4/05/21 at 4:29 p.m. revealed Client #1 walked out the front door and the Wanderguard system failed to activate the alarm. At 4:31 p.m. surveyor asked the Direct Support Supervisor (DSS) A to have Client #4 walk out the front door. Client #4 walked out the front door and the Wanderguard system failed to activate the alarm until after the client walked back in the door. Both Client #1 and Client #4 wore Wanderguard monitors due to a history of elopement attempts. The monitors should have triggered the Wanderguard alarm to sound when they went out the exit door. Observation on 4/06/21 at 6:50 a.m. Client #4	W 191	W 191 Staff Training Program Mosaic will ensure that all staff receive competency based training on client behavioral needs. Prior to working in the facility, staff will review all individual plans and be trained on any equipment utilized, including door alarms. There will be checks daily of alarms to ensure they are working properly. If a checks shows that the alarms is not working, DSA or DSS will contact the maintenance department and they will test the alarms to troubleshoot why it is not working. If they can not find the cause they will put an alternative alarm on the doors, when that alternate alarm is engaged, the maintenance dept will train the DSS or DSA on how the alternative alarm works and each shift as they come to work will be trained on the alternative alarm until all employees have been trained. Staff will put a T-log out, so all employees are aware that there is an alternative alarm on the doors. All employees will be retrained on responding to the door alarm going off. Each time the door alarm goes off, the closest employee will step out to the doors to see who is entering or leaving the home.	

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W 191	Continued From page 33 answered the front door. The Wanderguard system failed to activate the alarm until after the client walked back in the door. Observation on 4/13/21 at 11:27 a.m. Client #4 answered the front door. The Wanderguard system failed to activate the alarm until after the client walked back in the door. Observation on 4/05/21 and 4/13/21 also revealed small plastic alarms had been attached to the exit doors, which had an "on" and "off" switch. Those alarms sounded each time the exit door opened. The sound made by the small alarms was a different sound from the Wandgerguard alarm. Observation on 4/05/21 at 3:59 p.m. revealed the CMA entered the front door and the alarm sounded. Direct Support Associate (DSA) H continued meal preparation in the kitchen and DSA G continued the interview with the surveyor. Staff failed to respond when the alarm sounded. Observation on 4/05/21 at 4:46 p.m. DSS B exited the front door and the alarm sounded. Staff failed to check to see who exited the front door. When interviewed on 4/05/21 at 4:29 p.m. Direct Support Associate (DSA) G said the Wanderguard alarm had worked previously to her knowledge. She was not aware it had not been functioning correctly. When interviewed on 4/05/21 at 4:31 p.m. DSS A acknowledged the facility was aware the Wanderguard system was not working correctly and she thought the facility had ordered a new Wanderguard system. DSA A said the facility put	W 191	Continue W 191 The DSS will check the monitors on a regular basis to ensure they have not expired which will make them malfunction. DSS will also check/change the batteries on a monthly basis to ensure they are is good working order. Mosaic will ensure individual safety needs are identified in the Comprehensive Functional Assessment and addressed through programming as needed. Staff will be trained on each person's individual program plans. As member needs change, the CFA and corresponding IPP will be updated. Staff will be notified via Therap of any program updates and review. Person(s) Responsible: Associate Director Program Manager Direct Support Supervisor	07/31/2021

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the additional small alarms on the exit doors because the Wanderguard system had been malfunctioning.

When interviewed on 4/06/21 at 6:54 a.m. DSA B commented the Wanderguard system had not worked correctly since Client #4 had eloped on 3/20/21. DSA B said it only worked when Client #4 entered the facility instead of when he exited the facility.

When interviewed on 4/13/21 at 11:49 a.m. DSA B stated the facility installed the additional exit door alarms after Client #4 eloped from the facility on 3/20/21. DSA B acknowledged she received verbal notification to keep the alarms turned on, but had not received training regarding using the new door alarms as a replacement for the malfunctioning Wanderguard system.

When interviewed on 4/13/21 at 11:55 a.m. DSA K stated the facility trained her on the Wanderguard system. When asked about the additional exit door alarms, she stated she thought the alarms were there for extra assistance in the springtime. DSA K said she witnessed several times the additional alarm on the front exit door was turned off when she entered the facility.

When interviewed on 4/13/21 at 10:50 a.m. the Associate Director (AD) acknowledged the facility provided no formal training for the additional exit door alarms. She said the facility informed the staff the additional alarms were put in place in case the Wanderguard system did not work.

2. Observation on 4/06/21 at approximately 7:00

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a.m. revealed Client #4 told Direct Support Associate (DSA) A that DSA H had grabbed Client #1 and dragged him the night before. Client #4 demonstrated a grabbing motion above his wrist. At approximately 7:30 a.m. Client #4 indicated DSA H had grabbed Client #1's arm and dragged him to his room. DSA A reported the incident to management staff.

Record review on 4/14/21 revealed the facility investigation regarding Client #4's allegation of abuse made on 4/06/21. The facility investigated the allegation and determined abuse had not occurred. According to the investigation, Client #1's father and step-mother returned him to the facility on the evening of 4/05/21 after an outing. Client #1 would not get out of his parents' vehicle to go inside the facility. The parents, DSA G and DSA H were all involved with trying to get Client #1 inside the facility. Client #1's father reported that he and his wife had physically removed Client #1 from the vehicle and the parents and staff had attempted to get Client #1 inside by using a wheelchair, even though he was independently ambulatory.

When interviewed on 4/14/21 at 11:40 a.m. DSA A stated she promptly reported the allegation made by Client #4 on 4/06/21. She said she checked Client #1 for injuries after Client #4 made the allegation and saw none. DSA A said it could be challenging to get Client #1 to transition from one area to another, especially from his father's vehicle to the facility. She said Client #1 sometimes became behavioral and exhibited self-injurious behavior when his father brought him back to the facility after an outing. Staff tried snacks, electronic devices and the use of a wheelchair to try to convince Client #1 to go

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inside the facility. DSA A said Client #1 typically liked riding in a wheelchair, but it didn't always work. She said the staff needed more training on how to address the situation of Client #1 refusing to exit his father's vehicle and go into the facility.

When interviewed on 4/14/21 at 1:25 p.m. DSA G stated she was present when Client #1 arrived back at the facility with his parents on the evening of 4/05/21. Client #1 refused to get out of his father's vehicle, until his parents finally physically assisted him out of the vehicle. DSA G got a wheelchair and offered to push Client #1 around in it, but he was not interested. His parents physically picked him up and sat Client #1 in the wheelchair. DSA G and DSA H managed to get Client #1 through the first entry door into the vestibule, but then he got out of the wheelchair and tried to go back out the door. DSA G said DSA H put his arms around Client #1 and guided him inside the facility, through the second entry door. She said DSA H was behind Client #1 and put his arms around him like a bear hug, with DSA H's arms over Client #1's arms. DSA G said she felt that DSA H was just trying to get Client #1 safely inside, because sometimes he banged his head when upset. DSA G said she did not believe DSA H was being abusive or mistreating Client #1. She said it was common for Client #1 to refuse to leave his father's vehicle to go inside the facility when his father brought him back from outings. DSA G said staff had previously used Client #1's electronic tablet with videos to coax him into the facility, but his electronic tablet was broken and had not been replaced. She said staff had not received training on how to manage Client #1's refusal to go into the facility from his father's vehicle.

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When interviewed on 4/14/21 at 1:40 p.m. the Certified Medication Assistant (CMA) stated she was present at the facility passing evening medications when Client #1's parents brought him back to the facility on 4/05/21. She said DSA G and DSA H were outside for 15-20 minutes trying to get Client #1 to come inside the facility. The CMA saw DSA H walk into the facility carrying Client #1 in a type of bear hug. Client #1 had gone limp and refused to walk. DSA H held the client from behind, with his arms wrapped around him, but under Client #1's arms. The CMA said it was not uncommon for Client #1 to go limp and try to drop to the ground when he didn't want to do something. She said DSA H continued to carry Client #1 to his room, by holding him from behind. The CMA said DSA H did not appear to be angry with Client #1 or abusive, he was just trying to get the client to his room. The CMA stated it was always a problem when Client #1 came back from an outing with his parents because he didn't want to come inside.

When interviewed on 4/14/21 at 2:00 p.m. Client #1's father said Client #1 did not want to get out of the vehicle and go inside the facility on the evening of 4/05/21. He said this was not unusual. He and his wife physically got Client #1 out of their vehicle and put him in a wheelchair to take him into the facility. Client #1 got out of the wheelchair and tried to leave, but his father blocked him. Once they got him inside the first entry door, the parents left.

DSA H no longer worked at the facility and did not return a message from 4/14/21.

Record review on 4/14/21 of Client #1's Individual Support Program and Behavior Support Program

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W 191	Continued From page 38 (BSP) revealed no information regarding how to manage refusals to transition from one area to another. The BSP noted target behaviors of aggression, self-injurious behavior and elopement. The BSP did not direct staff to use a bear hug or physical interventions to move Client #1 from one area to another. The BSP noted staff could use Mandt physical restraint for medical procedures or if Client #1 was posing a danger to self or others. Client #1's record also contained no documentation of staff using a bear hug/physical escort to get Client #1 to his room on the evening of 4/05/21. When interviewed on 4/14/21 at 1:50 p.m. the Associate Director(AD) and the Program Manager confirmed the facility had not developed a program or procedure to address Client #1's ongoing difficulties with transitioning from vehicles to buildings. The AD-ICF noted it was also a problem with agency vehicles and going into other buildings, such as medical offices. She said Client #1's father had been picking him up for weekly visits for several months and the transition to return to the facility had been a continuing problem.	W 191		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249	W 249 Program Implementation Mosaic will ensure that all individuals have updated programs identified by the IDT. The IDT will discuss programming at all ISP planning meetings. QIDP will update all programs as discussed in the ISP within 30 days of the ISP date. When programs have been updated the QIDP will train all staff. DSS is responsible for training any staff the QIDP did not train directly. All staff will be	

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W 249	Continued From page 39 This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to consistently implement programs as identified in the Individual Support Plans. This affected 3 of 3 clients (Client #1, Client #2 and Client #3). Finding follows: 1. Observation on 4/05/21 at approximately 4:30 p.m. revealed Client #1 went out the exit door with Direct Support Associate (DSA) G present. DSA G failed to prompt Client #1 to push the switch by the door to indicate he was going outside. Observation on 4/06/21 at 9:43 a.m. revealed staff placed Client #1's communication board in front of him, but did not prompt him to use it. Client #1 got up from the table at 9:46 a.m. and walked around holding his glass. DSA J asked Client #1 verbally if he wanted more to drink instead of using his communication board for his response. Record review on 4/07/21 revealed Client #1's ISP with eight programs listed: use a communication board to indicate needs and wants; push a switch to indicate he wanted to go outside; sit on the toilet; sit at the table during meals; increase tooth-brushing skills; take his seizure medication and a behavior support program to decrease target behaviors. Additional record review revealed Client #1's program data for the months of December 2020, January 2021, and February 2021. Staff failed to document data for Client #1's programs 25% to 50% of the time for the month of December. Staff failed to document data for Client #1's programs 50% to	W 249	Continue W 249 trained on all adaptive equipment in the teaching plans. DSS, PM and QIDP will be conducting teaching plan observations monthly. Each will train staff if plan or adaptive equipment are not implemented correctly at the time of the observation. Each home will have an activity schedule with different activities for each individual in the home. DSS or PM will re-train staff of active treatment with a competency review to ensure they know what active treatment is and how to engage the individuals. Person(s) Responsible: QIDP Program Manager Direct Support Supervisor	07/1/2021

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75 % of the time in January and February. The lack of data indicated staff had not consistently implemented the programs.

When interviewed on 4/20/21 at 10:30 a.m. the QIDP indicated staff should consistently implement client programs.

2. Observation on 4/05/21 at 5:22 p.m. revealed DSA H brought Client #2's plate of food to the table for dinner. Client #2 took two bites of her food and left the table. She placed her plate on the counter. Client #2 then sat on the couch at 5:25 p.m. Staff failed to prompt Client #2 to wash her dishes after she completed her meal and placed her dish on the counter.

Observation on 4/05/21 from approximately 3:05 p.m. to 6:00 p.m. revealed staff failed to offer Client #2 leisure activities. Client #2 primarily sat in the dining room area unengaged.

Observation on 4/06/21 at 9:15 a.m. revealed DSA B prompted Client #2 to the table for breakfast. DSA B prepared Client #2's breakfast and placed the food in front of her. After she finished eating, Client #2 placed her dishes in the bin at the table and walked back to her room. Staff failed to prompt Client #2 to wash her dishes.

Record review on 4/08/21 revealed Client #2's ISP with the following programs: select a leisure activity; dishwashing, defined as placing her dishes in the sink, rinsing the dishes, and placing the dishes in the dishwasher; tooth brushing and a behavior support program. Additional record review revealed Client #2's monthly data

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W 249	Continued From page 41 summary for December 2020 indicated staff failed to document the data for the programs approximately 50% of the time. The January 2021 data summary noted a range of 33-66% of data trials missing and there was no data at all for the Leisure Activity program. The data summary for February 2021 noted a range of 33-66% of data trials missing and there was no data for the Leisure Activity program. When interviewed on 4/20/21 at 10:30 a.m. the QIDP indicated staff should consistently implement client programs. 3. Observations on 4/05/21 from approximately 3:05 p.m. to 6:00 p.m. revealed staff failed to offer Client #3 a choice between two positioning options or offer a switch to choose a sensory activity. Record review on 4/08/21 revealed Client #3's ISP with the following programs: communication-chooses between two positioning options; behavior/communication- activates a switch to choose a sensory activity; dental desensitization and a behavior support program to decrease target behaviors. The monthly data summary for December 2020 indicated staff failed to document the data for the programs approximately 50% of the time. The January 2021 data summary noted a range of 25-50% of data trials missing and there was no data at all for the Dental program. The data summary for February 2021 noted 75% of data trials missing and there was no data for the Dental program. When interviewed on 4/20/21 at 10:30 a.m. the QIDP indicated staff should consistently	W 249		

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W 249	Continued From page 42 implement client programs. 2. Intermittent observations on 4/06/21 from 6:50 a.m. to 9:50 a.m. revealed Client #2 lying on her bed in her bedroom with her bedroom door cracked open. No alarm sounded during this time. Observation on 4/13/21 at 11:30 a.m. revealed Client #2's bedroom door was cracked open. DSA B showed the surveyor a small plastic alarm on the top corner of Client #2's bedroom door. DSA B said the alarm was turned off. DSA B closed the door and reached up to the plastic alarm to turn it on. When DSA B opened the door, the alarm sounded loudly. DSA B then reached up to the plastic alarm to shut it off and proceeded to open Client #2's bedroom door slightly. DSA B indicated the alarm only worked when turned on and the shut door was opened. Record review on 4/08/21 revealed Client #2's behavior support program (BSP) with identified target behaviors including aggression, self-injurious behavior and PICA (ingestion of non-edibles). According to the BSP Client #2 sometimes left her room without staff knowledge. The BSP noted, "To keep her safe, an alarm is placed on her bedroom door and should be turned on whenever she is in her bedroom so staff are aware of her leaving her room." When interviewed on 4/20/21 at 10:30 a.m. the QIDP said she was unaware of the bedroom alarm on Client #2's door. The QIDP was new to the agency.	W 249		
W 259	PROGRAM MONITORING & CHANGE	W 259		

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W 259	Continued From page 43 CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to complete Comprehensive Functional Assessments (CFA) annually. This affected 2 of 3 sample clients (Client #2 and Client #3). Finding follows: 1. Record review on 3/08/21 revealed Client #2's CFA completed 2/15/19. A more recent CFA could not be located in Client #2's record. 2. Record review on 3/08/21 revealed Client #3's CFA completed 1/15/19. A more recent CFA could not be located in Client #3's record. When interviewed on 4/13/21 at 9:37 a.m. the Associate Director acknowledged the CFA should be done annually and had not been completed since 2019 for Client #2 and Client #3.	W 259	W259 Program Monitoring and Change Mosaic will ensure that each individual will have a CFA to identify needs. The QIDP will assigned the DSS or PM to complete a Comprehensive Functional Assessment each year prior the annual ISP. The CFA will assist the IDT in determining needed programming. Case file reviews are completed monthly on members who had an annual review the month prior to ensure the CFA, plan and corresponding documentation were completed in a timely manner. Person(s) Responsible: QIDP	07/31/2021
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure annual revision of Individual Program Plans. This affected 1 of 3 sample	W 260	W260 Program Monitoring and Change Mosaic will ensure all plans are reviewed annually and updated with in 30 days of the ISP meeting. The QIDP will have all programs, and plan in place within 30 days of the ISP mtg. Case file review takes place monthly for all ISP's completed the prior month to ensure all paperwork is in place per regulations. Person(s) Responsible: QIDP	07/31/2021

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W 260	Continued From page 44 clients (Client #3). Finding follows: Record review on 4/08/21 revealed Client #3's annual Individual Support Plan meeting held 12/19/19 with an effective date of 3/19/2020, which was 3 months after the annual meeting. A more recent ISP could not be located in Client #3's record. When interviewed on 4/08/21 at 9:22 a.m. the Qualified Intellectual Disability Professional (QIDP) stated the facility held Client #3's most recent annual ISP meeting on 4/06/21, but it had not yet been written. When interviewed on 4/12/21 at 3:09 p.m. the Associate Director stated the prior QIDP held Client #3's ISP meeting on 12/19/19, but she left the agency prior to writing the ISP document. Another agency QIDP later wrote the ISP and completed it in March 2020. The AD acknowledged Client #3's annual ISP meeting should have been held in December 2020. The ISP meeting held on 4/06/21 was almost four months overdue.	W 260		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to offer meaningful activities and promote client independence. This affected 2 of 3 sample clients (Client #1 and	W 268	W268 Conduct toward Client Mosaic will ensure that all individuals have meaningful days and promote independence. Each home will have a activity schedule with different activities for each individual in the home. DSS or PM will re-train staff of active treatment with a competency review to ensure they understand active treatment and how to engage the individuals. DSS, PM and QIDP will be completing active treatment observations monthly. The reviewer will review the findings of the observation	

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W 268	Continued From page 45 Client #2). Finding follows: 1. Observation on 4/05/21 from approximately 3:10 p.m. to 3:45 p.m. revealed Client #1 laid on the couch with a blanket. At 3:20 p.m., DSA H checked Client #1's brief while he laid on the couch. At 3:28 p.m. DSA G asked Client #1 how he was doing. At 3:34 p.m., DSA G blocked Client #1 from putting his feet on Client #2. Client #1 laid on the couch until 3:43 p.m. Client #1 then walked to the table and grabbed DSA G to walk with him. Client #1 had a snack at 3:45 p.m. and attempted to take it to his room. DSA G redirected him to the table but Client #1 ate his snack while standing up. Client #1 handed DSA G his bowl at 3:51 p.m. and grabbed her hand to get more chips. Client #1 walked to his room and ate his chips. Client #1 remained in his room until staff prompted him for medication at 4:18 p.m. The Certified Medication Aide spooned Client #1's medication mixed with oatmeal into his mouth while Client #1 held an electronic device and watched a video. Record review on 4/07/21 revealed Client #1's Personal Schedule, which indicated the expectation Client #1 would participate in the activity schedule. Examples of activities in the afternoon included work on domestics, clean own room, organize closet/dresser, organize shelves, remove items belonging to others, clean vanity, and clean own bathroom. Staff failed to offer any activity from the personal schedule during observation. Observations on 4/06/21 from 6:50 a.m. to 9:51 a.m. revealed Client #1 laid in his bed under the covers in his room. DSA B greeted Client #1 good morning at 8:10 a.m. Client #1 continued to lay in	W 268	Continue W268 with the staff that were observed. If there is evidence that training needs to reoccur, it will occur at that time. Person(s) Responsible: Direct Support Supervisor Program Manager QIDP	07/31/2021

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W 268	Continued From page 46	W 268		

bed. At 8:14 a.m., DSA B knocked on Client #1's door and prompted him to get up. Client #1 remained in his room. DSA B walked into Client #1's bedroom at 9:10 a.m. with medication placed in pieces of banana. DSA B gave her cell phone to Client #1 and he watched videos while he took his medication in the banana. Client #1 used DSA B ' s cell phone as she exited his room. At 9:38 a.m., DSA B prompted Client #1 to the table. DSA B prepared Client #1's breakfast and placed the plate of food in front of Client #1.

Record review on 4/07/21 Client #1's Personal Schedule, which indicated staff would be prompt Client #1 to participate in various morning activities. The examples included: get dressed, take medications, personal hygiene skills, assist with meal prep, wash hands, sanitize table, set own place at table, serve self, clear own dishes, use restroom, brush teeth, wash face and hands, sweeping, mopping, follow activity schedule, work on domestics, laundry, vacuum, dust, organize kitchen cupboards, organize items in own room. Staff prepared and served Client #1's breakfast without prompting him to participate. Staff failed to offer activities and tasks from the personal schedule during observation.

When interviewed on 4/20/21 at 10:30 a.m. QIDP acknowledged staff should be involving clients in daily activity with their programs, chores, mealtimes, and activities.

2. Observation on 4/05/21 from approximately 3:10 p.m. to 5:25 p.m. revealed Client #2 sat in the dining room area most of the time, with minimal staff interaction. At 3:35 p.m., staff asked Client #2 to move from the couch to the recliner after Client #1 kicked her. Client #2 then

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MOSAIC-102 KELLY'S COURT	102 KELLY'S COURT FOREST CITY, IA 50436

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W 268	Continued From page 47 sat in the recliner. Direct Support Associate (DSA) G asked Client #2 at 3:52 p.m. if she wanted water. DSA G brought Client #2 a glass of water to her recliner, which the client drank. Client #2 sat in the recliner until CMA prompted her to take her medication at 4:10 p.m. Client #2 then returned to sitting on the couch. DSA G prompted Client #2 to use hand sanitizer at 4:53 p.m. Client #2 declined and put her hands under her blanket. At 4:55 p.m., DSA G again prompted Client #2 to use hand sanitizer and Client #2 grabbed DSA G's hand. Client #2 sat on the couch until she independently walked to the dining table and sat down for dinner at 5:19 p.m. At 5:22 p.m., DSA H brought Client #2's plate of food to the table. Client #2 took two bites of her food and left the table. She placed her plate on the counter. At 5:25 p.m., Client #2 sat on the couch. Record review on 4/08/21 also revealed Client #2's Personal Schedule, which indicated the expectation Client #2 would participate in meal preparation. The examples included wash hands, roll silverware, stir/mix, sanitize table, set own place at the table, serve self, and clear own dishes. DSA H prepared Client #2's meal with no requested participation of Client #2. Staff failed to offer any activity from the personal schedule during observation. When interviewed on 4/20/21 at 10:30 a.m. QIDP acknowledged staff should involve clients in daily activity with their programs, chores, mealtimes, and activities.	W 268		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i)	W 323	W323 Physician Services Mosaic will ensure all annual physicals evaluations include vision and hearing.	

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W 323	Continued From page 48 The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure completion of annual vision and/or hearing screenings. This affected 3 of 3 sample clients (Client #1, Client #2 and Client #3). Findings follow: 1. Record review on 4/07/21 revealed Client #1's Audiology exam dated 4/24/19 noted the following findings: "Refusal-second attempt. Able to obtain tympanograms. Normal consistent with middle ear. Function could not obtain info re-hearing." A more recent hearing evaluation could not be located in Client #1's record. When interviewed on 4/20/21 at 10:15 a.m. the Nurse Manager verified the facility did not complete or obtain an annual hearing assessment for Client #1. The Nurse Manager acknowledged Client #1's annual physical checked the health of his ears, but did not assess hearing. 2. Record review on 4/08/21 revealed Client #2's Audiology Exam dated 8/21/19 noted the following findings: "1) continued medical care with physician 2) audio as medically necessary." A more recent hearing evaluation could not be located in Client #2's record. When interviewed on 4/20/21 at 10:15 a.m. the Nurse Manager verified the facility did not complete or obtain a annual hearing assessment	W 323	Continue W323 Nursing department will start a spread sheet of all annual physicals including vision and hearing and will ensure all of the annual physical are completed with in the time annual time frame. Case File reviews are completed on a monthly basis and health services are monitored through the case file reviews. Person(s) Responsible: Nursing Department	07/31/2021

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W 323	Continued From page 49 for Client #2. The Nurse Manager acknowledged the annual physical checked the health of her ears, but did not assess hearing. 3. Record review on 4/08/21 revealed Client #3's Audiology Exam dated 8/08/17. A more recent hearing assessment could not be located in Client #3's record. Client #3's record revealed an Optometry Exam completed on 3/26/19. A more recent vision assessment could not be located in Client #3's record. When interviewed on 4/20/21 at 10:15 a.m. the Nurse Manager verified the facility did not complete or obtain an annual hearing or vision assessment for Client #3. The Nurse Manager acknowledged the annual physical only checked the health of her ears and the eyes.	W 323		
W 334	NURSING SERVICES CFR(s): 483.460(c)(3)(i) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to complete the quarterly assessments in a timely manner and failed to include a direct physical assessment. This affected 3 of 3 sample clients (Client #1, Client #2, and Client #3). Finding follows: 1. Record review on 4/07/21 revealed Client #1's	W 334	W334 Nursing Services Mosaic will ensure that the health of all individuals are monitored on a quarterly basis. Therap has a module that the nursing department will use to complete the quarterly assessment that will include a physical assessment of each individual. The Nurse Manager will meet with the Therap consultant with Mosaic and will be trained on this new module and will in turn train the other nurses that will be completing the quarterly assessments. Quarterly Health Assessment are monitored during monthly case file reviews. Person(s) Responsible: Nurse Manager	07/31/2021

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W 334	Continued From page 50	W 334		

Health Care Report (Quarterly Nursing Assessment) for 10/01/2020-12/31/2020 dated 2/15/21 did not include a direct physical assessment.

Record review on 4/20/21 revealed Client #1's Health Care Report for 8/01/20 - 10/31/20 dated 12/10/20 did not include a direct physical assessment.

2. Record review on 4/08/21 revealed Client #2's Health Care Report (Quarterly Nursing Assessment) for 10/01/2020 - 12/31/2020 dated 2/15/21 did not include a direct physical assessment.

Record review on 4/20/21 revealed Client #2's Health Care Report (Quarterly Nursing Assessment) for 7/01/20 - 9/30/20 dated 4/20/21 did not include a direct physical assessment. Client #2's Health Care Report for 5/01/20 to 7/31/20 dated 8/04/20 did not include a physical assessment. Client #2's Health Care Report for 1/01/20 to 3/31/20 dated 4/15/21 did not include a physical assessment. The month of April was not included in any of the quarterly reports.

3. Record review on 4/08/21 revealed Client #3's Health Care Report (Quarterly Nursing Assessment) for 10/01/2020 - 12/31/2020 dated 2/15/21 did not include a direct physical assessment.

Record review on 4/20/21 revealed Client #3's Health Care Report for 8/01/20 - 10/31/20 dated 12/10/20 did not include a direct physical assessment. Client #3's Health Care Report for

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W 334	Continued From page 51 4/01/20 - 6/30/20 dated 4/15/21 did not include a direct physical assessment. Client #3's Health Care Report for 1/01/20 to 3/31/20 dated 4/15/21 did ont include a direct physical assessment. The month of July was not included in any of the quarterly reports. When interviewed on 4/14/21 at 9:02 a.m. the Registered Nurse acknowledged the quarterly Health Care Reports did not include direct physical assessments. She did not offer an explanation as to why the reports were done at a later date.	W 334		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to complete annual dental examinations. This affected 1 of 3 sample clients (Client #3). Finding follows: Record review on 4/08/21 revealed the Dental Examination Form dated 3/09/20 for Client #3 recommended "evaluating in 6 months at next visit in Forest City for possible need of extractions." A more recent dental exam could not be located in Client #3's record. When interviewed on 4/20/21 at 9:55 a.m. the Nurse Manager acknowledged there was no	W 352	W352 Comprehensive Dental Diagnostic Service Mosaic will ensure the health of the individual are completed annually. The dentals are recommended for every 6 months. Due to the pandemic , Mosaic was not able to reevaluate with in the 6 month that was recommended. Through out the pandemic Mosiac was not able to make appointment any physicians or dentist. Dental appointments have been set up for Oct. 2021 with the University of Iowa which is the only dentist that will see our individuals in our rural area. Person(s) Responsible: Nursing Department	07/09/2021

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W 352	Continued From page 52 follow up dental appointment for Client #3 since the last dental exam on 3/09/20. The Nurse Manager stated the University of Iowa Dental Clinic did not see patients during the COVID pandemic. She said stated the agency nursing department had begun to schedule University of Iowa dental appointments for clients, however Client #3's appointment had not yet been scheduled.	W 352		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to secure medications until administered. This potentially affected 4 of 4 mobile clients (Client #1, Client #2, Client #4 and Client #5). Finding follows: Observation on 4/05/2021 at 4:05 p.m. revealed the Certified Medication Aide (CMA) placed pills in a medication cup for Client #1 on the counter of the medication room. The CMA exited the medication room with the door open to prepare oatmeal in the kitchen area for Client #1. The CMA left the medication unsecured. The CMA returned to the medication room with the oatmeal and poured the medication in the oatmeal. At 4:14 p.m. the CMA again exited the medication room leaving the door open with Client #1's medication in a bowl of oatmeal on the counter. The CMA moved Client #3 in her wheelchair to the living area next to the kitchen and left the	W 382	W 382 Drug Storage and Record Keeping Mosaic will ensure all Certified Medication Aide is properly trained of securing of medication until administered. Nurse Manager will retrain the CMA of the proper securing methods of medications. Nursing department, PM, and DSS will be completing Medication administration observation on a regular basis to ensure the medication passes are correct and the medications are secure. Person(s) Responsible: Nursing Department Program Manager Direct Support Supervisor	07/31/2021

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W 382	Continued From page 53 medication unsecured for the second time. Record review on 4/08/2021 revealed Client #2's behavior program, which noted she had a PICA disorder and also might acquire food inappropriately. Record review on 4/14/21 Medication Supports Policy revealed, "In ICF/ID, a locked drawer cabinet, cupboard, closet, etc., for medication will be used in each home. The CMA or nurse who is administering the medications or who opens the locked medication cabinet is responsible for securing the key at all times." When interviewed on 4/05/2021 at 4:44 p.m. Direct Support Supervisor A confirmed medication should not be left unsecured. When interviewed on 4/12/2021 at 2:45 p.m. the Nurse Manager confirmed the CMA should have secured the medication.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to conduct first shift fire drills at varied times. This potentially affected 5 of 5 residents living at the facility (Client #1, Client #2, Client #3, Client #4 and Client #5). Finding follows: Record review on 4/06/21 revealed first shift fire	W 441	W441 Evacuation drills Mosaic will ensure the safety of all individuals. PM will retrain DSS on the evacuation times. The drills will vary the time of day and day of the week. The Safety Committee will view the drills on a monthly basis to ensure that drills cover a variety of days/times. Person(s) Responsible: Safety committee Direct Support Supervisor Program Manager	07/31/2021

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W 441	Continued From page 54 drills in the past year completed on the following dates and times: 1/18/21 at 10:00 a.m., 10/17/20 at 10:00 a.m., 7/14/20 at 9:30 a.m. and 4/12/20 with no time listed. All fire drills were held within a 30 minute time frame, between 9:30 a.m. and 10:00 a.m. When interviewed on 4/13/21 at 9:39 a.m. the Associate Director confirmed the times of the fire drills, which were not varied.	W 441		